CHAPTER 9 — HEALTH CARE SERVICES

ARTICLE 1 — NURSING SERVICES PROGRAM

Effective June 16, 1995

93040.1 Policy

Each facility shall plan for and provide quality nursing care that is commensurate with that provided in community health facilities.

Each facility shall establish an organized nursing services department to ensure the provision of quality nursing care.

93040.2 Purpose

The nursing services department shall be an organized system for the provision of individualized patient care based upon established standards of care utilizing the nursing process, i.e., assessment, planning, intervention, and evaluation.

Each facility shall establish written standards of care, that are consistent with the Department's Office of Health Care Services objectives and community care standards. These standards of care shall be utilized in planning, providing, and evaluating nursing care.

93040.3 Responsibility for Health Care Services

The CMO or other physician director shall be responsible for all health care services at each facility.

93040.4 Responsibility of the Director of Nursing Services

The nursing services department shall be directed by a qualified RN with training and experience in nursing administration and supervision.

- All Department general acute care hospitals shall be under the direction of a Supervising Nurse II/III. The Supervising Nurse II/III shall not serve as charge nurse.
- All Department infirmaries may be directed by either a Supervising Nurse II or an SRN as determined by patient care needs.

The nurse services director shall have authority and responsibility for all nursing services in the facility. The responsibility and accountability of the nursing services to the medical staff and administration shall be defined.

93040.5 Nursing Services Licensure and Certification

Each facility shall establish a method for verifying the current licensure of each RN, LVN, and MTA. Only those with current licensure shall be assigned patient care duties in hospitals or infirmaries.

Nurses working in expanded roles, i.e., nurse practitioners and nurse anesthetists, shall maintain current, appropriate certification.

93040.6 Nursing Services Organization

Nursing services shall be organized and staffed to ensure the supervision and coordination of nursing care by an RN.

All provisions of nursing care shall be under the supervision of an RN.

A sufficient number of RNs and MTAs shall be on duty at all times to provide nursing care according to patient needs.

93040.7 Nursing Services Organizational Plan

An organizational chart shall be developed defining lines of authority and accountability for each level and service of nursing staff.

93040.8 Nursing Services Procedures

Each facility shall develop and maintain written policies and procedures for the safe and effective provision of quality nursing care.

Nursing policies and procedures shall be developed in coordination with all departments and established for every patient service area.

Policies shall be approved by the governing body. Procedures shall be approved by the medical staff and administration.

Each nursing service employee shall be trained in the policies and procedures during orientation and whenever new policies or procedures are established.

Nursing policies and procedures shall be reviewed annually and revised as required to reflect current standards of nursing practice.

93040.8.1 Nursing Services Procedural Guidelines

Each nursing policy and procedure shall:

- Be established in writing.
- Identify the classification of staff approved to perform the procedure.
- Include a list of required equipment/supplies.
- Indicate any precautions or required special observations.
- Provide an easily understood, detailed, step-by-step procedure.
- State medical record and other documentation requirements.
- Include the dates of approval and revision.

93040.9 Nursing Scope of Practice

Each RN shall perform their duties according to the scope of practice as stated in the B&PC 2725, “Practice of Nursing Defined.”

Specifically selected and trained RNs may perform beyond the normal scope of practice only by utilizing standardized procedures as defined in B&PC 2725(d)(2). Each standardized procedure shall be developed and supervised by a committee on interdisciplinary practice. Each standardized procedure shall be developed according to the California Board of Registered Nurses, “Standardized Procedure Guidelines.”

Each MTA shall perform their duties according to the "Scope of Regulation," B&PC Article 2, 2959.

MTAs may perform patient care activities only under the direction of a physician or an RN.

93040.10 Nursing Services Staff Development Program

Each facility shall plan and conduct an ongoing nursing staff development program to ensure appropriate training of all nursing staff.

93040.10.1 Components of a Nursing Services Staff Development Program

Each staff development program shall include the following:

- Written attainable educational goals and objectives.

- An annual training plan.
- An orientation program for all newly hired nursing staff which includes orientation to all applicable institutional policies and procedures, to the medical services areas, and to the specific job assignment.
- Continuing IST based upon identified educational needs.
- An annual or more frequent review for all nursing staff of cardio-pulmonary resuscitation and infection control procedures.
- Specific area training for nursing staff required to work in specialized patient care areas, i.e., surgery, emergency, psychiatry, and hemodialysis.
- Training of nursing staff who are required to perform procedures which require additional training, i.e., intravenous fluid administration, cardiac monitoring, standardized procedures.
- An annual evaluation of the nursing education program for compliance with the standards of care and educational goals and objectives.

93040.10.2 Nursing Services Continuing Education Courses

Nursing staff shall participate in outside educational programs when required training cannot otherwise be obtained. Records of such training should be retained by the nursing services director or nurse instructor.

Facilities that employ a qualified nurse instructor may obtain approval from the Board of Registered Nurses and Board of Vocational Nurse and Psychiatric Technician Examiners to provide continuing education credit for nursing staff training.

93040.10.3 Nursing Services Training Documentation

Records of all orientation and IST shall be maintained which include:

- Date and time of presentation.
- Name and title of presenter.
- Course title and objective.
- Summary of course content.
- Signatures of staff attending.

93040.11 Nursing Services Reference Materials

Each facility shall maintain current reference materials including textbooks, journals, and periodicals to complement the training and staff education program.

93040.12 Psychiatric Nursing Services

Psychiatric nursing policy and procedures shall be established at all facilities providing inpatient and/or outpatient care for mentally disordered inmates.

93040.12.1 Psychiatric Nursing Services Requirements

An RN with training and experience in psychiatric nursing shall be immediately available whenever a patient is admitted to an inpatient unit for psychiatric care.

Nursing staff shall participate in psychiatric treatment planning.

Psychiatric nursing service policies and procedures shall be developed in consultation with other appropriate health professionals and administration.

93040.13 Nursing Services Job Descriptions

A written job description shall be established for each nursing position specifying performance standards, delineating functions, responsibilities, and specific qualifications.

93040.14 Nursing Services Staffing Requirements

Sufficient registered nursing personnel shall be provided to assure the direction and provision of nursing care at all times.

Each hospital nursing unit shall have an RN immediately available at all times.

An RN with training and experience in operating room techniques shall be responsible for operating room service.

An RN with training and experience in post-anesthesia nursing care shall be responsible for the nursing care in the hospital post-anesthesia unit.

An RN with training and experience in emergency room procedures shall be immediately available at all times to provide emergency nursing care in facilities providing emergency care.

MTAs may be utilized as needed to supplement RNs in ratios appropriate to patient needs.

Each infirmary shall have at least one RN immediately available 24 hours a day, seven days a week.

93040.15 Nursing Services Staffing Based on Patient Classification System

Each general acute care hospital shall establish and implement a patient classification system to ensure adequate and appropriate staffing based on patient needs.

The patient classification system shall include the following patient assessments:

- The patient's ability to care for themselves.
- The patient's degree of illness.
- The patient's requirements for special nursing activities.
- The skill level required by staff for their care.
- The patient's placement in the nursing unit.

The methodology used in making determinations shall be established and maintained in writing.

Written staffing records shall include the total number of nursing staff, the available nursing care hours for each nursing unit, and the categories of nursing staff available for patient care and shall be retained for a minimum of six months.

Each facility shall maintain a record for every nursing staff employed from an outside agency that includes the following:

- Documentation of orientation to facility policies and procedures and duties as assigned.
- Verification of current licensure with documentation of license number and expiration date.
- Records of dates and hours worked.

93040.16 Assignment of Nursing Services Patient Care: Inpatient Units

Each patient's nursing care shall be planned, supervised, and evaluated by an RN.

An RN shall assess the care needs of each patient admitted to a hospital or infirmary prior to assigning nursing staff.

Nursing staff shall only be assigned to duties that are commensurate with their training, experience, and skill.

93040.17 Assignment of Nursing Services Patient Care: Outpatient Services

An RN shall be responsible for the nursing care provided in the outpatient setting.

93040.18 Nursing Services Process: Patient Care Plan

Nursing process is a title used to describe a system of providing patient care that includes assessment, planning, implementation, and evaluation.

Patient care planning is the utilization of the nursing process for the provision of individual patient care.

A written patient care plan shall be initiated upon admission and developed within seven days in coordination with the total health team for each hospital and infirmary patient. The patient care plan shall be the basis for the provision of nursing care.

93040.19 Nursing Services Patient Assessment

Each patient upon admission to an inpatient unit shall be assessed by an RN for the identification of patient care needs.

The patient assessment shall include:

- Medical history.
- Physical condition.
- Social status.
- Emotional status.
- Knowledge deficit.

The nursing patient assessment shall be completed in writing, shall be included in the patient's medical record, and shall be used to identify patient care needs.

A continuing assessment of patient care needs shall be maintained throughout the patient's admission.

93040.19.1 Nursing Services Psychiatric Patient Assessment

An RN with training and experience in psychiatric nursing shall assess the mental health status, using behavioral terminology where appropriate, of all patients admitted to an inpatient psychiatric unit.

93040.19.2 Nursing Services Patient Assessment Guidelines

The following guidelines should be utilized in performing the initial patient assessment.

- Conduct a patient interview in an area affording privacy and freedom from interruption if possible.
- Inform the patient that the requested information shall be used in planning their care.
- Inquire as to the patient's medical history and reason for admission to the unit. Assess their knowledge of their medical condition.
- Inquire as to the patient's emotional/spiritual condition. Are they angry, anxious, afraid?
- Be alert to the patient's non-verbal responses, mood changes, or hesitancy in answering. These may indicate social, emotional, or educational needs.
- Observe the patient's physical condition including vital signs, weight, height, nutritional state, skin condition, physical limitation, vision, hearing, injuries, wounds, infections, and other. Utilize a body systems approach. Document in detail in the patient's medical record all observations and findings.
- Document on the patient care plan all patient care needs identified by the patient assessment.

93040.20 Nursing Services Diagnosis

A nursing diagnosis is a clinical diagnosis made by an RN to describe actual or potential health problems which nurses, by virtue of their education and experience, are capable of and licensed to treat.

Nursing service departments may use nursing diagnoses or may describe patient needs in other terms.

93040.21 Nursing Services Patient Care Planning

A plan of care shall be developed in writing for every identified patient need.

The plan of care shall include realistic, attainable goals for each identified patient need.

The plan of care shall include specific patient care activities designed to attain the goals.

Each patient care plan shall include the anticipated date for goal attainment and the staff member responsible for each element of patient care.

93040.22 Nursing Services Patient Care Plan Implementation

All nursing staff shall review the patient care plans of their assigned patient daily to ensure the provision of patient care as planned.

Nursing staff shall provide all patient care consistent with the patient care plan.

Medical record nursing notations shall reflect the implementation of the care plan.

93040.23 Nursing Services Patient Care Plan Evaluation

All patient care plans shall be maintained current.

A review and updating of the plan is required when any of the following occur:

- A change in patient condition.
- A change in the physician's plan of care.
- A failure of the current plan to accomplish the identified goals.
- A failure of the patient to accept or respond to the plan.
- The identification of any additional patient care needs.

The date anticipated for goal attainment has been reached.

93040.24 Nursing Services General Documentation Guidelines

All medical record documentation shall be consistent with the following guidelines:

- All entries shall be timed, dated and signed, including title, by the person making the entry.
- All entries shall be in chronological order except as a documented “late entry.” All late entries shall include the date and time when written as well as date and time for which entry is made.
- All entries shall be typed or written in black ink.
- Error correction procedures shall include the use of a single line drawn through the entry and the initials or signature, if not otherwise present, of the individual making the correction.
- The entry made in error shall not be obliterated. "White-out" correction fluid shall not be used.
- All medical record forms shall include the patient's full name and CDC number.
- All entries shall be legible.
- Cellophane or other tape shall not be used to adhere any medical record form onto a medical record. Only permanent bond glue may be used for this purpose.
- The use of abbreviations shall be restricted to those included on an approved abbreviation list.

93040.25 Nursing Services Inpatient Documentation Guidelines

Nursing staff provide a significant portion of the clinical information contained in inpatient medical records. Consistent, accurate nursing documentation is essential for quality and continuity of patient care. All nursing staff shall adhere to the following documentation guidelines when making entries in inpatient records:

- Nursing notes shall be specific, pertinent, concise, and reflect the implementation of the patient care plan.
- Nursing notes shall include the following documentation:
    - All changes in patient signs, symptoms, or condition.
    - All physician communications and notifications.
    - Patient-expressed complaints or concerns.
    - Laboratory specimen collections.
    - Radiology procedures performed.
    - Diagnostic or other procedures performed.
    - Patient visitor.
    - Patient education or counseling.
    - All patient-involved unusual occurrences.
    - The inability to follow a physician's order with documentation of the reason and physician notification.
    - Specific observations of the patient's behavior, activity, conversation, progress, or regression.
    - Daily observations of tubes, catheters, wounds, drains, and dressings including changes.
    - The initiation of intravenous fluid administration including site and type of needle/catheter.
    - Postoperative observations including urinary output, breath sounds, and other as appropriate.
    - Any treatment administration or procedure not documented on a treatment record.
- All documentation of medication and treatment administrations shall be exactly as ordered including time and frequency.
- All documentation of pro-re-nata (PRN - as required) medication administration shall include the reason for the administration and patient response.
- All documentation of medication injections shall include location and rotation of site.
- All documentation of intravenous fluid administration shall include the type of fluid, the quantity, and any additives.
- Vital signs, weights, clinitesting, and physician-prescribed observations or care shall be documented as prescribed.
- Nursing staff receiving verbal or telephone physician's orders shall immediately document the order in the medical record including date, time, and name of physician making the order.
- Nursing staff noting physician's orders shall sign, date, and time the orders.
- Upon patient discharge or transfer, nursing staff shall complete a summary of information regarding the patients inpatient course for those responsible for the patient's continued care. When the patient is being discharged to a general housing unit, the summary may be limited to discharge instructions and the patient shall receive a copy of these instructions. A copy of the summary shall be retained in the patient's medical record.
- Food intake and patient personal hygiene shall be documented as provided.

93040.26 Nursing Services Outpatient Documentation Guidelines

Nursing documentation shall be included in the patient's outpatient medical record upon every patient visit.

The documentation shall be consistent with the inpatient documentation guidelines.

Nursing outpatient medical record documentation shall include:

- Date, time, and location of patient visit.
- Patient complaints.
- Observations of patient's condition.
- Vital signs whenever the patient complains of illness, major injury, or other acute symptoms.
- Notification of the physician if the physician is not present.
- Noting of physician's orders.

- Documentation of all medications, treatments, and procedures administered.
- Documentation of patient discharge instructions.

93040.27 Nursing Services Audit

Each nursing services department shall establish a nursing medical record audit procedure to evaluate the quality of medical record documentation on a regular ongoing basis.

The identified medical record documentation deficiencies shall be incorporated into the nursing staff development program.

93040.28 Nursing Services Staff Committee

A nursing committee or committees shall be established to assist in the planning, development, and evaluation of the nursing service.

The nursing committee shall be composed of RNs and MTAs.

The nursing committee shall meet as often as necessary, but at least every two months, to identify problems in the provision of nursing care and to develop and implement solutions to these problems.

A written, systematic method shall be developed and implemented for evaluating the quality of nursing care.

Minutes shall be recorded at each nursing committee meeting indicating the names of the members present, date, subject matter discussed, and actions taken.

The nursing staff committee may perform the nursing audit procedure.

93040.29 Responsibility of Nursing Services Toward Infection Control

An RN with training and experience in infection control shall be assigned to surveillance and monitoring for infection control.

The RN shall be a member of the hospital or infirmary infection control committee.

93040.30 Revisions

The Deputy Director, HCSD, or designee is responsible for ensuring that the contents of this section are kept current and accurate.

93040.31 References

CCR (22) §§ 70213-70215, 70706(2), 70719(c)(2), and 70721(a)(e).

California Correctional Association Standards, 2-2101, 2-4079, 2-4084, 2 4088, 2-4091, 2-4401, 2-4271, 2-4276, and 2-4283.

B&PC Chapter 6, Article 2, §§ 2732-05 and 9958; Chapter 6, § 2725; and Chapter 6-5, §§ 2859 and 2873.6.

ARTICLE 2 — LABORATORY SERVICES

Effective June 16, 1995

93052.1 Policy

Each Department health care facility shall provide appropriate space, equipment, supplies, and personnel for the performance of clinical laboratory tests for the examinations, care, and treatment of inmates. Provisions shall be made for 24-hour emergency clinical laboratory services.

93052.2 Purpose

Clinical Laboratory Services shall provide operational guidelines for clinical laboratory practices consistent with the Department's administrative directives, ACA Standards, CCR, and B&PC.

93052.3 Responsibility of the Clinical Laboratory Services Staff

The clinical laboratory staff are responsible for:

- Developing policies and procedures to ensure the satisfactory collection, processing, and disposal of laboratory specimens.
- Developing procedures for the provisions of prompt and accurate examinations for each test to be performed.
- Developing procedures to ensure the safety and protection of all personnel.
- Providing consultation to clinicians in the interpretation of diagnostic tests/results.
- Participation in continuing education health care and infection-control programs.
- Maintaining accurate and complete records.
- Developing an effective communication system between the clinical laboratory and infirmary staff.
- Developing a peer review process to ensure that adequate laboratory standards are maintained.
- Demonstrating satisfactory performance in an ongoing proficiency testing program, as required by Laboratory Field Services.

93052.4 Clinical Laboratory Services Operational Requirements

To accomplish its purpose effectively and safely, each clinical laboratory shall have:

- An area large enough to accommodate laboratory equipment and staff movement.
- A preventive maintenance schedule for each piece of equipment.
- Clutter-free testing areas.
- Toilet facilities adjacent to or in the immediate vicinity.
- Sufficient area for storing supplies, filing data, and properly disposing of refuse.
- Twenty-four hour emergency coverage.
- If tests are to be performed on outpatients, outpatient access to the laboratory shall not traverse an inpatient nursing unit.

93052.5 Clinical Laboratory Services Provided On-Site

A list of services provided on-site shall be available to all medical staff. These services are laboratory procedures generally considered routine and may include, but not be limited to, the following:

- Urinalysis.
- Complete blood counts.
- Blood typing.
- Blood cross-matching.
- Chemistry.
- Microbiology.
- Serology.
- Hematology.
- Toxicology.
- Bacteriology.
- Specimen collection/processing/disposal.

93052.6 Clinical Laboratory Services Provided Off-Site

Clinical laboratory services are contracted if they require special equipment and/or specialized personnel unavailable on-site.

93052.6.1 Clinical Laboratory Services Off-Site Criteria

For services that are not provided on-site, each health facility shall make contractual arrangements for services to be provided off-site.

When necessity dictates clinical laboratory services to be provided off site, the contract shall specify:

- The contracted laboratory is licensed to operate in California and conform to the requirements of the B&PC and CCR (17).
- Time frames for regular and emergency pickup service.
- Time limits for the return of clinical laboratory reports for regular and emergency service.
- Access to clinical laboratory director for interpretation of reports.
- Competitive fee schedule.
- All other requirements necessary in the formulation of State contracts.

DOM 22040, discusses contracts in detail.

93052.7 Clinical Laboratory Services Director

The pathologic and clinical laboratory shall be directed by a physician who is qualified to assume professional, organizational, technical, and administrative responsibility for the unit and the services rendered.

The physician shall be certified or be eligible for certification in clinical pathology and/or pathologic anatomy by the American Board of Pathology. If a full-time or regular part-time employee is unavailable to fill this position, a consultant with comparable qualifications shall be retained on a contractual basis to provide these services as often as required.

93052.7.1 Clinical Laboratory Services Technologist

The clinical laboratory technologists shall be licensed by the State of California. They shall display their valid license in a conspicuous area of the laboratory.

93052.7.2 Performance of Technical Clinical Laboratory Activities by Unlicensed Persons

CCR (17) explains in some detail the limited activities allowed unlicensed persons working in licensed clinical laboratories. Questions have arisen, however, related to some activities not specifically mentioned. The following are some of these activities:

- Unlicensed persons (including phlebotomists) shall not perform:
  - Bleeding times.
  - Urine dipstick tests.
  - Hematocrit tests.
  - Sedimentation rates.
  - Glucose testing by any method.
  - Any other clinical laboratory test.
- Unlicensed persons shall not make any decision related to the reading of standard or control results for any test procedure, automated or not.
- CCR (17) requires that all laboratory results shall be, “critically reviewed and verified for accuracy, reliability, and validity” by a duly licensed person prior to sending out any reports.

93052.7.3 Performance of Clinical Laboratory Medical Tasks by Inmates

Inmates shall not be permitted to perform duties such as:

- Obtaining blood samples.
- Administering blood.
- Introducing or discontinuing intravenous infusions.
- Any other task identified as medical or nursing functions.

93052.8 Authority for Clinical Laboratory Services

Clinical laboratory examinations shall only be conducted pursuant to the order of a person lawfully authorized to give such an order.

93052.9 Procedures for Clinical Laboratory Specimen Collection/Disposition of Data

Each clinical laboratory shall establish procedures to ensure that:

- Specimens are collected, processed, and disposed of in a medically acceptable manner.
- Examinations are performed accurately.
- Results are reported promptly upon completion of test.
- All clinical laboratory reports shall remain an integral part of the patient's health record. See also DOM 93052.9.1.
- Each hospital shall maintain blood storage facilities in conformance with the provisions of CCR (17). Such facilities shall be inspected at appropriately short intervals every day to ensure fulfillment of the statutory requirements.

93052.9.1 Requirements for Retention of Clinical Laboratory Services Records

The following is a summary of the record retention requirements of the Department, Medi-Cal, and Medicare programs:

- All inmate and QC records shall be retained for twoyears except cytologic reports which shall be kept for ten years. Cytology slides shall be kept for five years.
- The Medi-Cal program requires all patient and QC records be retained for three years. This includes all written requests for laboratory tests.
- 42 CFR related to the Medicare program requires all patient and QC records be kept for two years.

93052.9.2 Requirements for Retention of Clinical Laboratory Services Printouts

For automated equipment where results of standards, controls, reaction limits, and patient information are recorded on printouts, these printouts along with all other records shall be retained for 90days.

If the inmate and QC information on the printouts is transferred to other records, the printouts may be discarded after 90days; otherwise they would fall under the mandates of DOM 93052.9.1.

93052.10 Information Required on Clinical Laboratory Forms

Only standardized departmental forms shall be used when requesting and recording any medical data. The request for a test shall identify the following information:

- The person making the request.
- The inmate.
- The test required.
- Time the request reached the laboratory.
- Date and time the specimen was obtained.
- Time the laboratory completed the test.
- Any special handling required.

- Name and address of laboratory.

93052.11 Clinical Laboratory Guidelines for AIDS, ARC, HIV, and Hepatitis

Employees having needle stick exposure (the accidental breaking of the skin of staff by an exposed hypodermic syringe) to suspected HIV, AIDS, ARC, and Hepatitis shall be reported to the facility CMO and ongoing records maintained for the staff exposed. The employee shall be treated by his or her own physician as a work-related injury.

All clinical laboratory specimens shall be labeled to allow for special handling. They shall be handled by trained personnel wearing gloves.

93052.12 Clinical Laboratory Services Infection Control Program

A formal infection control program shall be adopted and shall conform to the guidelines in the most recent edition of "Infection Control in the Hospital" published by the American Hospital Association.

93052.12.1 Clinical Laboratory Membership on the Infection Control Committee

A qualified staff member of the clinical laboratory service shall be a member of the hospital's infection control committee.

93052.13 Clinical Laboratory Services QC System

A QC system designed to assess functional efficiency in all facets of clinical laboratory operations, and to ensure reliability and proper handling of the data generated shall be established. QC activities shall be conducted on an ongoing basis.

93052.13.1 Staff Evaluation of Clinical Laboratory Services

In accordance with hospital bylaws, at least annually, a committee of hospital staff shall evaluate services provided and make appropriate recommendations to the medical executive committee and the health facility administration.

93052.14 Revisions

The Deputy Director, HCSD, or designee is responsible for ensuring that the contents of this section are kept current and accurate.

93052.15 References

PC §§ 5054 and 5058.

CCR (15) (3) §§ 3350 and 3354.

CCR (17) §§ 1002 and 1030 through 1057.

CCR (22) §§ 70055(a)(9), 70241, 70243, 70245, 70247, 70251, 70253, 70255, 70257, 70259, 70739, and 70837.

42 CFR.

H&SC § 25100 et seq.

B&PC Rules 1200 through 1322.

ACA Standards 2-4271, 2-4274, 2-4275, 2-4277, 2-4282, 2-4284, and 2-4310.

DOM § 22040.

ARTICLE 3 — RADIOLOGY SERVICES

Effective June 16, 1995

93053.1 Policy

Each Department health care facility shall provide appropriate space, equipment, supplies, and personnel for the performance of radiological services for the examinations, care, and treatment of inmates. Provisions shall be made for 24-hour emergency radiology services.

93053.2 Purpose

Radiological Services shall provide operational guidelines for radiological services consistent with the Department's administrative directives, ACA, and California Radiation Control Regulations.

93053.3 Radiological Services

Radiological service means the use of x-ray, other external ionizing radiation, and/or thermography, and/or ultrasound in the detection, diagnosis, and treatment of human illnesses and injuries. Ultrasound, although properly the province of physical medicine, may be considered part of the radiological service.

93053.4 Responsibility of Radiological Services

To achieve its purpose, the radiological unit shall:

- Take, process, and interpret radiographs and fluoroscopes.
- Establish and implement policies and procedures to ensure protection to all personnel in contact with radiation.
- Provide consultation and advice to clinicians.
- Interpret roentgenological findings.
- Plan and implement diagnostic x-ray procedures.
- Make additional postmortem examinations to complete records.
- Participate in hospital's educational program.
- Maintain and keep accessible, accurate, and complete records.
- Provide sufficient space, equipment, supplies, and personnel.
- Provide 24-hour emergency service.

93053.5 Radiological Services Provided On-Site

A published list of services provided on-site shall be available to all staff. These services are diagnostic radiological services up to and including fluoroscopic examinations.

3053.6 Radiological Services Provided Off-Site

The radiology unit shall make contractual arrangements for services to be provided off-site if these are specialized radiological procedures requiring staff and equipment unavailable on-site.

93053.7 Director of Radiological Services

A physician shall be responsible for the radiological service. The physician shall be a certified radiologist or eligible for certification by the American Board of Radiology. If such a person is not available on a full-time or regular part-time schedule, a physician with equivalent qualifications shall be retained on a contractual basis to provide supervision and direction for the service.

93053.8 Radiological Services Technologists

All radiology technicians shall be personnel licensed by the State of California as certified radiology technicians. All radiology staff licenses shall be valid and posted in a conspicuous place in the radiological unit.

93053.9 Requirements for Radiological Services

All radiological studies shall be performed under the order of the licensed physician or other licensed health professional lawfully authorized to prescribe the procedure.

93053.10 General Radiological Services Requirements

Written policies and procedures shall be developed and maintained by the person responsible for the service.

- The responsibility and accountability of the radiological service to the medical staff and administration shall be defined.
- A technologist shall be available to the unit during operational hours.
- The monitoring of radiology personnel and monthly recording of the cumulative radiation exposure of each individual shall be performed.
- The director shall be responsible for verifying the qualifications and capabilities of all radiological personnel.
- A QC program shall be maintained to minimize the unnecessary duplication of radiographic studies, and to maximize the quality of diagnostic information available.
- Positive proof of collimation (cut-off margins on radiographs) and gonad shielding (mark visible on radiographs) shall be present on all radiographs if gonadal shielding is indicated.
- Film shall not be “double exposed.”
- Manufacturer's recommended guidelines shall be followed for the use and periodic maintenance of all equipment.
- Inmate's records shall be properly filed and retained for the same period as other parts of inmate's medical record.
- Sign-out procedures shall be stringently adhered to.

93053.11 Radiological Services Forms/Records

Only standardized departmental forms shall be used when requesting and recording radiological data. The request shall include:

- Proper identification of the requesting physician.
- Proper identification of the inmate.

- A history pertinent to the examination requested.

Radiological services staff shall maintain accurate and complete records/reports that shall be incorporated into the inmate's medical file and a copy maintained in the radiology unit.

When an inmate is transferred to another facility, all x-rays shall be forwarded to the receiving health facility.

Upon an inmate's death, discharge, parole, or interstate transfer, all records/film shall be retained by the last health facility for a minimum of seven years.

93053.12 Radiological Services Safety Procedures

Radiation protection for all staff and inmates shall be strictly enforced during all radiological examinations. Lead aprons and/or other safety devices shall be utilized to ensure maximum available protection.

The use, storage and handling of all radiation machines and radioactive material shall comply with the California Radiation Control Regulations and CCR.

All diagnostic equipment shall be calibrated annually. A physicist shall be available as needed for consultation.

If x-ray examinations are to be performed on outpatients, outpatient access to the radiological areas shall not traverse an inpatient-nursing unit.

93053.13 Infection Control Program for Radiological Services

A formal infection control program shall be adopted to conform to the guidelines addressed in the most recent edition of "Infection Control in the Hospital" published by the American Hospital Association. Activities of this program shall include:

- Ongoing surveillance of patients and staff.
- Prevention techniques.
- Treatment/referral.
- Documenting infection related incidences expeditiously.
- Reporting any occurrence which threatens the welfare, safety and/or health of inmates, staff, and/or visitors.

93053.14 Infectious Waste in Radiological Services

Infectious waste containers shall be provided for all:

- Examining rooms.
- Emergency care rooms.
- Dental operatories.

All infectious wastes, as defined in H&SC 25117.5, shall be handled and disposed of in accordance with the Hazardous Material Control Law, Chapter 6.5, Division 20, 25100 et seq., H&SC and the regulations adopted thereunder.

93053.15 Radiological Services Audits/QC

Refer to DOM 93053.13.

93053.16 Revisions

The Deputy Director, HCSD, or designee is responsible for ensuring that the contents of this Article are kept current and accurate.

93053.17 References

PC §§ 5054 and 5058.

CCR (15) (3) §§ 3350 and 3354.

CCR (17) §§ 1002 and 1030 - 1057

CCR (22) §§ 70055(a)(9), 70241, 70243, 70245, 70247, 70251, 70253, 70255, 70257, 70259, 70739 and 70837.

42 CFR.

H&SC § 25100 et seq.

B&PC §§ 1200 - 1322.

ACA Standards 2-4271, 2-4274, 2-4275, 2-4277, 2-4282, 2-4284, and 2-4310.

ARTICLE 4 — INVOLUNTARY PSYCHOTROPIC MEDICATIONS

Effective June 18, 1997

99010.1 Policy

The Department may administer involuntary psychotropic medication to an inmate if certain procedures are followed.

99010.2 Purpose

The purpose of this Article is to set forth CDC's responsibilities and inmates' rights concerning administration of involuntary psychotropic medications.

99010.3 Definitions

Informed Consent

Informed consent means that the inmate, without duress or coercion, clearly and explicitly manifests consent to the proposed medication to the treating physician in writing. In order to obtain informed consent, the following information shall be given to the inmate in a clear and explicit manner:

- The reason for treatment, that is, the nature and seriousness of the person's illness, disorder, or defect.
- The nature of the procedures to be used in the proposed treatment, including its probable frequency and duration.
- The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.
- The nature, degree, duration, and the probability of the side effects and significant risks, commonly known by the medical profession, of such treatment, including its adjuvants, especially noting the degree and duration of memory loss (including its irreversibility) and how and to what extent they may be controlled, if at all.
- That there exists a division of opinion as to the efficacy of the proposed treatment (if such a division of opinion exists), why and how it works, and its commonly known risks and side effects.
- The reasonable alternative treatments, and why the physician is recommending this particular treatment.
- That the individual has the right to accept or refuse the proposed treatment, and that if he or she consents, he or she has the right to revoke that consent for any reason, at any time prior to or between treatments.

Incompetent to Refuse Medication

An inmate is "incompetent to refuse medication" or "lacks the capacity to refuse medication" if the inmate cannot understand or knowingly and intelligently act upon the information specified under "informed consent" above. An inmate shall not be deemed incompetent to refuse medication or lacking the capacity to refuse medication solely by virtue of being diagnosed a mentally ill, disordered, abnormal, or mentally defective person.

Gravely Disabled

An inmate is "gravely disabled" if the inmate, as a result of a mental disorder, is unable to use the elements of life that are essential to health and safety including food, clothing, and shelter, even though provided to the inmate by others. Examples of grave disability might include:

- Deterioration in personal hygiene.
  - Unable to maintain reasonably clean surroundings.
  - Soils clothes, urinates in the bed or on the floor, smears feces on the wall or on the body.
  - Unable or refuses to shave, take shower, change clothes to the degree that the body smells and becomes very dirty and unhygienic.
- Refusal of food.
  - Refuses to go to the dining room, or refuses food when tray is brought.
  - Throws food away without eating or unable to eat without one-to-one assistance.
  - Loss of weight and poor nutritional condition due to poor eating or starvation.
- Destructive behavior.

  Sets fire in the cell or mattress without regard for safety consequences.
  - Floods the cell.
  - Breaks windows.

Danger to Others

An inmate is a "danger to others" only if at least one of the following exist:

- The inmate has attempted, inflicted, or made a serious threat of substantial physical harm upon the person of another, after having been taken into an inpatient psychiatric unit and who presents, as a result of mental disorder, a demonstrated danger of inflicting substantial physical harm upon others.
- The inmate has attempted or inflicted physical harm upon the person of another, that act having resulted in being taken into the inpatient psychiatric unit, and the person presents, as a result of mental disorder, demonstrated danger of inflicting substantial physical harm upon others.
- The inmate had made a serious threat of substantial physical harm upon the person of another within seven days of being taken into an inpatient psychiatric unit, that threat having at least in part resulted in being taken into the inpatient psychiatric unit, and the person presents, as a result of mental disorder, demonstrated danger of inflicting substantial physical harm upon others.

Danger to Self

An inmate is a "danger to self," if, as a result of a mental disorder, the inmate, while in an inpatient psychiatric unit, threatens or attempts to take his or her own life or threatens, attempts, or inflicts serious physical injury on him/herself and who continues to represent an imminent threat of taking his or her own life or an imminent threat of inflicting serious physical injury on him/herself.

Inpatient Psychiatric Unit

An inpatient psychiatric unit is any inmate housing in which both psychiatric care and 24-hour nursing care is accessible.

Involuntary Medication

Involuntary medication refers to the administration of any psychotropic or anti-psychotic medication or drug to any person by the use of force, discipline, or restraint. It includes the administration of any such medication or drug to a person who does not give informed consent as defined herein.

Psychotropic or Antipsychotic Drugs

The terms “psychotropic drugs” and “anti-psychotic drugs” refer to drugs or medications used in the treatment of mental disease, mental disorder, or mental defect.

99010.4 General Provisions

Involuntary medication shall not be used:

- To control behavior that is not related to a diagnosable psychiatric disorder.
- When an inmate is capable of giving informed consent and objects to such medication, unless dangerous to self or others.

Involuntary medication shall not be given:

- In doses above approved levels unless approved by a written statement in the inmate's medical record by the Health Care Manager (HCM) or Chief Psychiatrist (CP).
- For purposes other than those for which the drug is approved by the Food and Drug Administration or by community standards of professional practice.

99010.4.1 Involuntary Medication Log

A continuous daily log of all involuntary medications administered shall be maintained by the medication nurse or MTAs/LVNs under the direction of the SRN in the unit or nursing station. Each entry in the log shall include:

- Inmate's name and CDC number.
- Physician ordering the medication.
- Reason for medication.
- Date of initial involuntary medication.
- Date, time, route of administration, and whether accompanied by use of restraint for each involuntary medication.
- Date of scheduled certification review hearing and result.
- Expiration date of judge's order, if any, authorizing administration of involuntary medication.
- Expiration date of certification period (no later than 24 days after day 1 of involuntary medication).
- Expiration date of interim order for psychotropic medication (no later than 47 days after day 1 of involuntary medication).

The log shall be reviewed and signed monthly by the HCM/CP.

99010.4.2 Place of Involuntary Medication Administration

Involuntary psychotropic medication may not usually be administered to an inmate in a housing unit. Prior to the administration of such medication, the inmate shall usually be transferred to the:

- Hospital.
- Clinic.
- Emergency room.
- Infirmary.
- Inpatient psychiatric unit.

If a physician determines that transfer of the inmate to such a medical setting would pose a greater risk to the inmate and staff than the risk involved to the inmate in receiving medication in a non-medical setting, the medication may be administered in the housing unit, or other location, provided that:

- Custody staff shall be alerted, orally and in writing on a CDC Form 7219, Medical Report of Injury or Unusual Occurrence, by medical staff that medication has been administered, the time and date of administration, and possible side effects that may develop.
- In all cases where it is both feasible and medically desirable, a fast-acting medication shall be utilized to facilitate the inmate's rapid transfer to a medical setting.
- A staff psychiatrist shall consider the inmate for transfer to a medical setting from his cell at least once a day after the injection for the effective duration of the medication. The staff psychiatrist shall note his/her observations and decision in writing. The inmate shall be transferred to a medical setting no later than 72 hours after the injection if the effective duration of the drug administered exceeds that time period.

99010.4.3 Medication Supervision

A physician or RN shall be physically present to observe the administration of involuntary medication. The physician's progress notes or the nursing notes shall include:

- Personnel administering the medication.
- Observation.
- Location of administering of the medication.
- Resistance.
- Force.
- Injury.
- Reaction.

99010.4.4 Documentation

Documentation of dangerousness or of grave disability and incompetence to render an informed consent shall be entered in the medical/psychiatric file.

99010.5 Emergency Medication

In the clinical judgment of a physician that an emergency situation exists, the physician may order involuntary medication for a period not to exceed 72 hours. An emergency exists when there is a sudden marked change in the inmate's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate or others, and it is impracticable to first obtain consent. If psychotropic medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the inmate. The physician shall document that informed consent information was given or if not, the reason it was not given.

99010.6 Procedures for Long-Term Involuntary Medication, up to 24 Days

If involuntary medication has been administered to an inmate for 72 hours or less, the inmate may be certified for an additional 21 days of involuntary medication related to the mental disorder when both of the following conditions are met:

- The clinical staff of the facility where the inmate is incarcerated has evaluated the inmate's condition and found that the inmate is, as a result of mental disorder, any of the following:
  - Gravely disabled and incompetent to refuse medication.
  - A danger to self.
  - A danger to others.
- The inmate has been advised of the need for, but has not been willing to accept, medication on a voluntary basis.

99010.6.1 Notice of Certification

For an inmate to be certified for involuntary medication for 21 days beyond the initial 72 hours, a notice of certification shall be signed by two people. The first person shall be the CP or designee. A designee of the CP shall be a psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders.

The second person shall be the physician or psychologist who participated in the evaluation. The physician shall be, if possible, a board certified psychiatrist. The psychologist shall be licensed and have at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders.

If the CP, or designee, is the physician or psychologist who performed the evaluation, the second person to sign shall be another physician or psychologist unless one is not available, in which case a social worker or an RN who participated in the evaluation shall sign the notice of certification.

CDC Form 7363, Notice of Certification

A CDC Form 7363, Notice of Certification, is required for all persons certified for the additional 21 days beyond the initial 72 hours of involuntary medication.

99010.6.2 Inmate Copy of CDC Form 7363

A copy of the CDC Form 7363 shall be personally delivered to the certified inmate, the inmate's attorney, or the attorney or advocate designated. The certified inmate shall also be asked to designate any person who is to be sent a copy of the certification notice. If the certified inmate is incapable of making this designation at the time of certification, the inmate shall be asked to designate a person as soon as the inmate is capable. Delivery of the notice shall take place within five days after the initial involuntary medication.

99010.6.3 Information Required to be Given to Certified Inmate

At the time of delivery of the CDC Form 7363, the inmate shall be informed, through use of the CDC Form 7366, Inmate Rights, Authorization for Involuntary Medication, that he or she is entitled to a certification review hearing, to be held within ten days of the initial involuntary medication, unless judicial review is requested, to determine whether or not probable cause exists to subject the inmate to involuntary medication related to the mental disorder.

The certified inmate shall be informed of his or her rights with respect to the certification review hearing, including the right to the assistance of another person to prepare for the hearing and/or to answer other questions and concerns regarding involuntary medication.

The person delivering a copy of certification to the certified inmate shall inform the inmate, at the time of delivery, of the legal right to judicial review by habeas corpus, shall explain that term to the certified inmate, and inform the inmate of the right to counsel, including court appointed counsel.

99010.6.4 Preparing for a Certification Review Hearing

As soon as practical after the certification, an attorney/advocate shall meet with the inmate to discuss the involuntary treatment process and to assist the inmate in preparing for the certification review hearing, or to answer questions or otherwise assist the inmate in preparing for the hearing. The attorney or advocate shall be provided with timely access to:

- Health care records.
- C-File.
- All documents and files relied upon in seeking authorization to involuntarily medicate the inmate.

When the inmate is unable or unwilling to sign such a release, the staff of the facility, upon satisfying itself of the identity of the attorney/advocate, and of the fact that the attorney/advocate does represent the interests of the inmate, shall release all such information and records relating to the inmate.

99010.6.5 Certification Review Hearing

When an inmate has been certified for involuntary medication, a certification review hearing shall be held:

- Within ten days of the initial involuntary medication, unless postponed for up to 48 hours by inmate, attorney, or advocate.
- Unless judicial review has been requested by the inmate seeking a petition for a writ of habeas corpus.

99010.6.5.1 Certification Review Hearing Officer

Certification review hearings shall be conducted by either a court-appointed commissioner or referee, or a certification review hearing officer.

The certification review hearing officer shall be one of the following:

- A State-qualified administrative law hearing officer.
- A medical doctor.
- A licensed psychologist.
- An RN.
- A lawyer.
- A licensed clinical social worker.

Licensed psychologists, licensed clinical social workers, and RNs who serve as certification review hearing officers shall have a minimum of five years' experience in mental health. Certification review hearing officers shall be selected from eligible persons unanimously approved by a panel composed of the local mental health director, the public defender, and the DAs of the county in which the facility is located. No employee of CDC shall serve as certification review hearing officer.

Certification Review Hearing Officers shall be initially identified by the Regional Senior Psychologists of HCSD, Operations. LAD shall be responsible for submitting the proposed names to the Public Defender, DA, and the Mental Health Director of the county in which the facility is located. Once approval is obtained, LAD shall notify the Keyhea coordinator at the facility.

To identify counsel to represent an inmate in a Keyhea proceeding, LAD shall consult the Public Defender of the county in which the facility is located. If the Public Defender is unwilling or unable to represent the inmate, then he or she shall be asked for a recommendation of other persons who would be able to serve in that capacity. Once the person has been identified, LAD shall notify the Keyhea coordinator at the facility.

99010.6.5.2 Location of Certification Review Hearings

The certification review hearing shall be:

- Conducted at the facility where the certified inmate is receiving treatment.
- Conducted in a location that is compatible with and least disruptive of the treatment being provided to the inmate.

99010.6.5.3 Presentation of Evidence at Certification Review Hearing

The evidence in support of the certification decision shall be presented by a person designated by the Warden of the facility. The certified inmate shall be present at the hearing unless he or she, with the assistance of the attorney or advocate, waives the right to be present.

99010.6.5.4 Inmate's Rights at the Certification Review Hearing

At the certification review hearing, the certified inmate shall have the following rights, that shall be explained to him/her through the use of CDC Form 7366, as required in DOM 99010.6.3:

- Assistance by an attorney/advocate.
- To present evidence on his/her own behalf.
- To question persons presenting evidence in support of the certification decision.
- To make reasonable requests for the attendance of facility employees who have knowledge of, or participated in, the certification decision.

99010.6.5.5 Procedures Regarding Certification Review Hearing

If the inmate has received medication within 24 hours or such longer period of time as the person conducting the hearing may designate prior to the beginning of the hearing, the person conducting the hearing shall be informed of that fact and of the probable effects of the medication.

The hearing shall be conducted in an impartial and informal manner in order to encourage free and open discussion by participants. The person conducting the hearing shall not be bound by rules of procedure and evidence applicable in judicial proceedings.

All evidence that is relevant to establishing that the certified inmate is or is not, as a result of mental disorder, either gravely disabled and incompetent to refuse medication or a danger to others or a danger to self may be admitted at the hearing and considered by the hearing officer.

At the conclusion of the certification review hearing, if the person conducting the hearing finds that there is not probable cause to believe that the certified inmate is, as a result of mental disorder, either gravely disabled and incompetent to refuse medication or a danger to others or to self, then the certified inmate may no longer be involuntarily medicated. Physicians at the institution shall ensure that withdrawal from medication is accomplished in a medically appropriate manner.

In determining whether there is probable cause to believe that the inmate is incompetent to refuse medication, the person conducting the certification review hearing shall determine whether there is probable cause to believe that the inmate is incapable of understanding or intelligently acting on the informational factors listed in the definition of "informed consent."

If at the conclusion of the certification review hearing the person conducting the hearing finds that there is probable cause to believe that the certified inmate is, as a result of mental disorder, either gravely disabled and incompetent to refuse medication or a danger to others or to self, then the inmate may be involuntarily medicated for a period of up to 21 additional days beyond the end of the 72 hour period following the initial involuntary medication.

The certified inmate shall be given oral notification of the decision at the conclusion of the certification review hearing. The attorney or advocate for the certified inmate and the Warden of the facility where the inmate is receiving medication shall be provided with a written notification of the decision including a statement of the evidence relied upon and the reasons for the decision. The CDC Form 7367, Certification Hearing Notice, shall be used to satisfy this requirement. The attorney or advocate shall notify the certified inmate of the certification review hearing decision and of the inmate's right to file a request for termination of involuntary medication and to have a hearing on the request before an administrative law judge. A copy of the decision of the hearing officer and certification notice shall be submitted to the administrative law judge.

99010.7 Procedures for Long-Term Involuntary Medication for More Than 24 Days

Inmates who have been certified for the additional 21 days of involuntary medication shall not be involuntarily medicated beyond 24 days after the initial involuntary medication, unless an order has been obtained from an administrative law judge in accordance with the procedures set forth below.

Once involuntary medication has begun, the total period of involuntary medication, including intervening periods of voluntary treatment, shall not exceed the total maximum period during which the inmate could have been involuntarily medicated if the inmate had been medicated continuously on an involuntary basis, from the time of the initial involuntary medication.

99010.7.1 Filing of Petitions, Temporary Order, Service on Inmate

Prior to involuntarily medicating an inmate for more than 24 days, CDC's LAD, or other counsel in accordance with State law, shall file a petition with the Office of Administrative Hearings seeking an order authorizing involuntary medication. The petition filed with the Office of Administrative Hearings shall meet the requirements set forth in Section III-A of the permanent injunction, dated October 31, 1986 and any subsequent modification to that injunction, in the matter of Keyhea v. Rushen (178 Cal. App. 3d 526). CDC shall ensure that the inmate is provided with the procedural protections set forth above.

An administrative law judge may authorize CDC to involuntarily medicate an inmate for a period of no more than 23 days beyond the end of the certification period, if CDC petitions for a temporary order and submits supporting affidavits clearly establishing the necessity for the temporary order. CDC must provide three-days notice to the inmate and to his or her attorney (if one has been appointed or retained) of the request for a temporary order. The petition and supporting documents requesting the temporary order must be personally served on the inmate and his or her attorney at least three days prior to the judge's ruling on the temporary order.

99010.7.2 Procedural Protections

The inmate or his/her attorney may file a response to the petition within five days of the service of the petition on the inmate or attorney. The facility shall file the petition and personally serve a copy of the petition on the inmate or attorney at least 15 days prior to the hearing on the petition. In lieu of personal service on the inmate's attorney, he/she may be served by mail at least 20 days prior to the hearing. At least 15 days prior to the hearing, the facility shall serve a copy of the petition on the inmate's next-of-kin or on the persons listed in the inmate's records maintained by the facility to receive notification in case of emergency. Service on such individuals may be made by mail.

99010.7.3 An Inmate's Right to Assistance of Counsel

Any attorney appointed or otherwise obtained shall be provided timely access to all documents specified in the section above relating to preparation for the certification review hearing.

99010.7.4 Inmate's Attendance at Judicial Hearing

The inmate shall be present at the hearing except:

- Where the inmate is unable to attend the hearing by reason of medical inability, and CDC obtains an order from an administrative law judge authorizing the nonattendance of the inmate.
- If the petition alleges or the CDC contends the inmate is unable to attend the hearing because of medical inability, such inability shall be established by affidavit/certificate of a licensed medical practitioner. This document is evidence only of the inmate's inability to attend the hearing and shall not be considered in determining the issue of need for an order authorizing involuntary medication. Emotional or psychological instability is not good cause for the absence of the inmate from the hearing unless attendance is likely to cause serious and immediate psychological damage to the inmate.
- Where an investigator, or the prisoner's attorney, reports to the administrative law judge that the inmate has expressly communicated his/her refusal to attend the hearing or does not wish to contest the petition.
- If the petition alleges or CDC contends that the inmate is not willing to attend the hearing, or upon the filing of an affidavit or certificate attesting to the medical inability of the inmate to attend the hearing, CDC shall request that an investigator or the inmate's attorney be directed to do all of the following:
- Interview the inmate personally.
- Inform the inmate of:
- The contents of the petition.
- The nature, purpose, and effect of the proceeding.
- The right to oppose the proceeding, attend the hearing, have the matter tried by jury, be represented by legal counsel if he/she so chooses, and have legal counsel appointed if unable to retain legal counsel.
- Determine whether it appears that the inmate is unable and/or unwilling to attend the hearing.
- Determine whether the inmate wishes to contest the petition.
- Determine whether the inmate wishes to be represented by legal counsel and, if so, whether the inmate has retained legal counsel and if not, the name of an attorney the inmate wishes to retain.

99010.7.5 Right to Expedited Hearing

The inmate or attorney shall have the right to file a written demand for an expedited judicial hearing on the petition. If the demand is filed, the hearing shall commence within ten days of the date of filing.

99010.8 Rehearing Rights

Once a judge has issued an order authorizing involuntary medications, the inmate has a right to petition the administrative law judge for a rehearing to contest whether he/she presently is a danger to others; a danger to self; or gravely disabled and incompetent to refuse medication. No further petition for rehearing shall be submitted for a period of six months.

99010.9 Initiation of Long-Term Involuntary Medication Within 30 Days of Judicial Denial of Petition

In the event an inmate who has been found by the administrative law judge not to meet the criteria for involuntary medication within the preceding 30 days is administered anti-psychotic medications in an emergency, and such emergency condition is likely to last beyond 24 hours, the treating physician shall file a new petition within 48 hours. The inmate or his/her attorney may file a request for an expedited hearing on the petition. If such a request is filed, the hearing shall be held within five days of the filing of the request.

99010.10 Renewal of Involuntary Medication Orders

No later than one month before an order authorizing the administration of involuntary medication is due to expire, the clinical staff of the facility where the inmate is currently housed shall evaluate the inmate to determine whether renewal of the order is appropriate. Renewal is appropriate if the inmate, even after administration of anti-psychotic medication, still has no insight into his/her mental illness, if he/she refuses to accept that he/she has a mental illness or needs medication, or if it is clear that the inmate, but for the medication, would be dangerous or gravely disabled once again. If clinical staff determine that renewal is appropriate, the procedures outlined in these sections for filing of petitions shall be followed (i.e., no certification or certification review hearing is necessary).

99010.11 Revisions

The Deputy Directors, HCSD and LAD, or designees are responsible for ensuring that the contents of this section are kept current and accurate.

99010.12 References

PC § 2600.

CCR (15) (3) § 3364.

DOM §§ 62030, 62050, and 62080.

Keyhea v. Rushen (178 Cal. App. 3d 526).

The Consent Decree entered in Whitaker v. Rushen, (USDC, No. C-81-3284 SAW (N.D. Cal).

In re Conservatorship of Walker, (206 Cal.App.3d 1572), (254 Cal.Rptr. 552 (5th DCA, 1989).